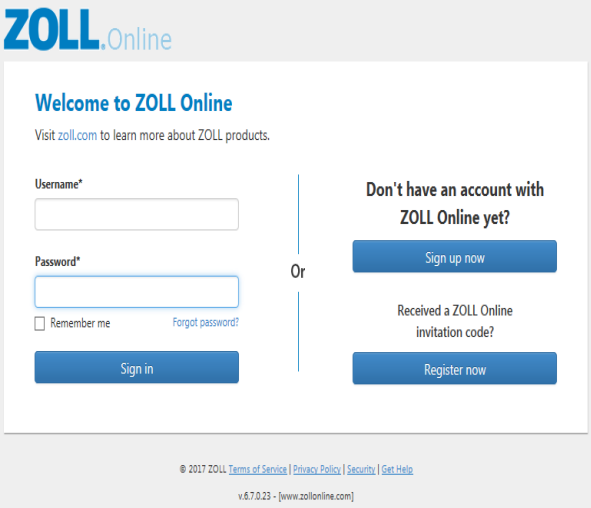
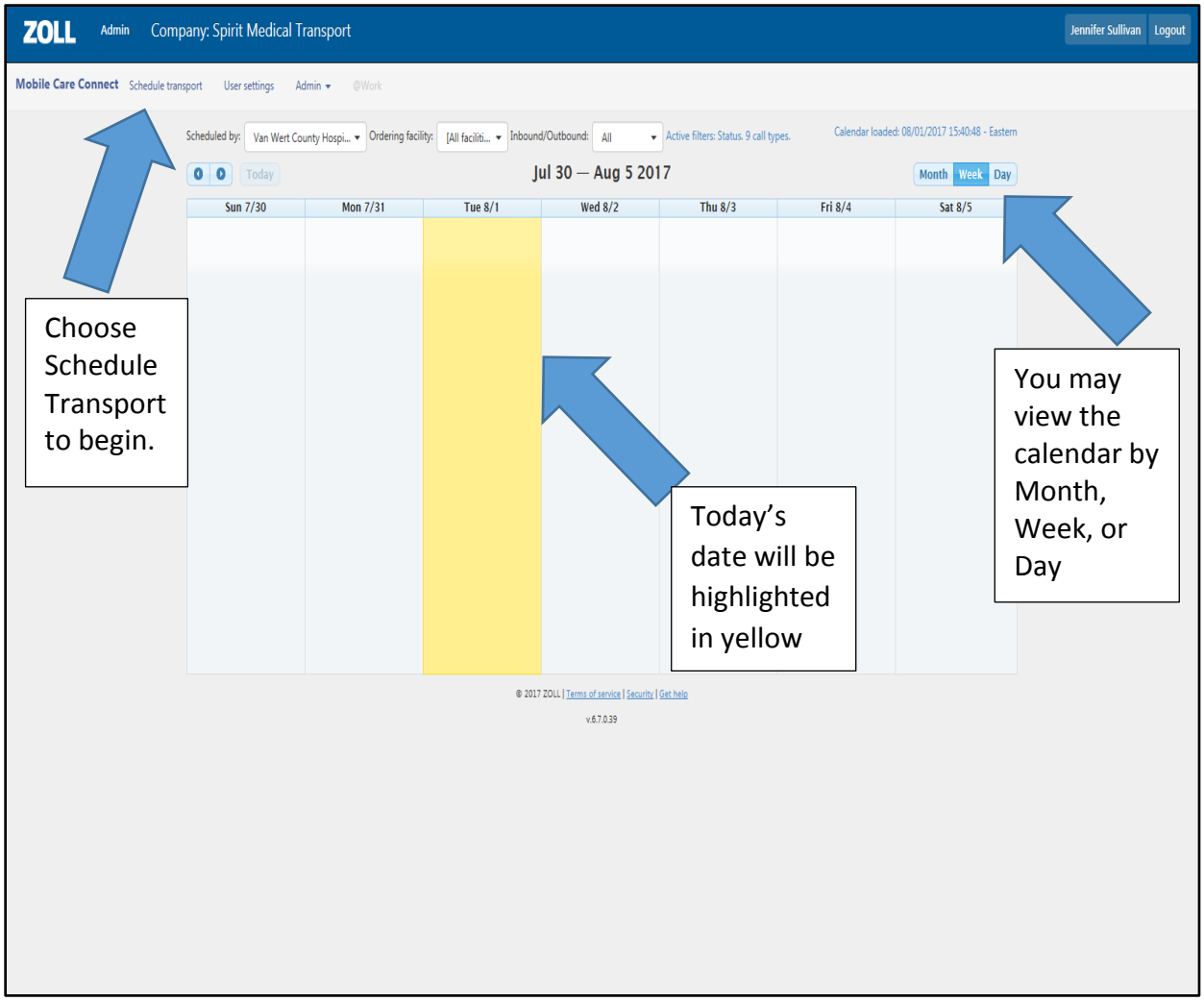
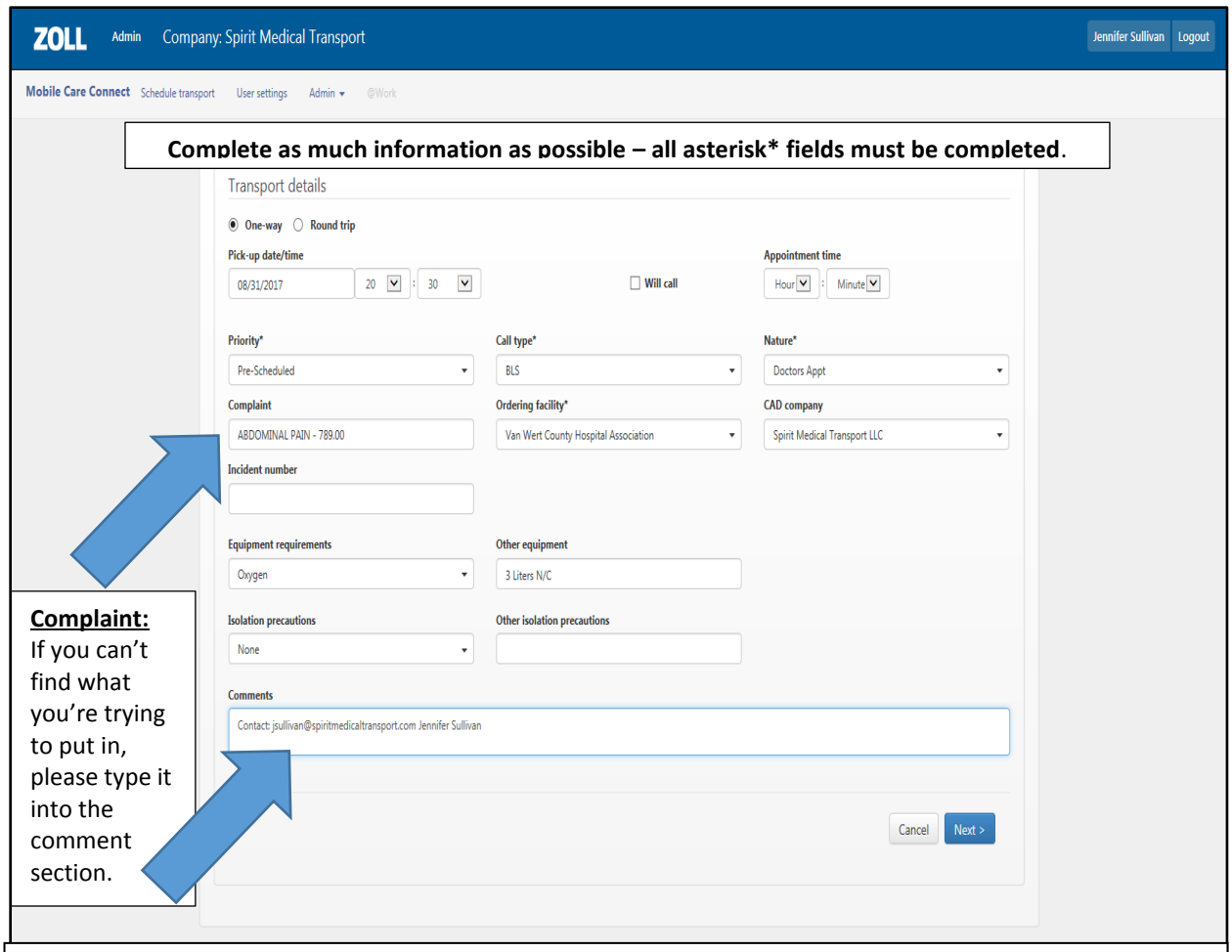
Mobile Care Connect Training



To begin - log into
https://www.zollonline.com
and sign-in with your
Username* and Password*


ZOLL
Admin
Company: Spirit Medical Transport
Jennifer Sullivan
Logout
Mobile Care Connect
Schedule transport
User settings
Admin
@Work
Scheduled by:
Van Wert County Hospi...
Ordering facility:
[All faciliti...
Inbound/Outbound:
All
Active filters: Status. 9 call types.
Calendar loaded: 08/01/2017 15:40:48 - Eastern
Today
Jul 30 — Aug 5 2017
Month
Week
Day
Sun 7/30
Mon 7/31
Tue 8/1
Wed 8/2
Thu 8/3
Fri 8/4
Sat 8/5
© 2017 ZOLL | Terms of service | Security | Get help
v.6.7.0.39
Choose Schedule Transport to begin.
Today's date will be highlighted in yellow
You may view the calendar by Month, Week, or Day



Priority*:

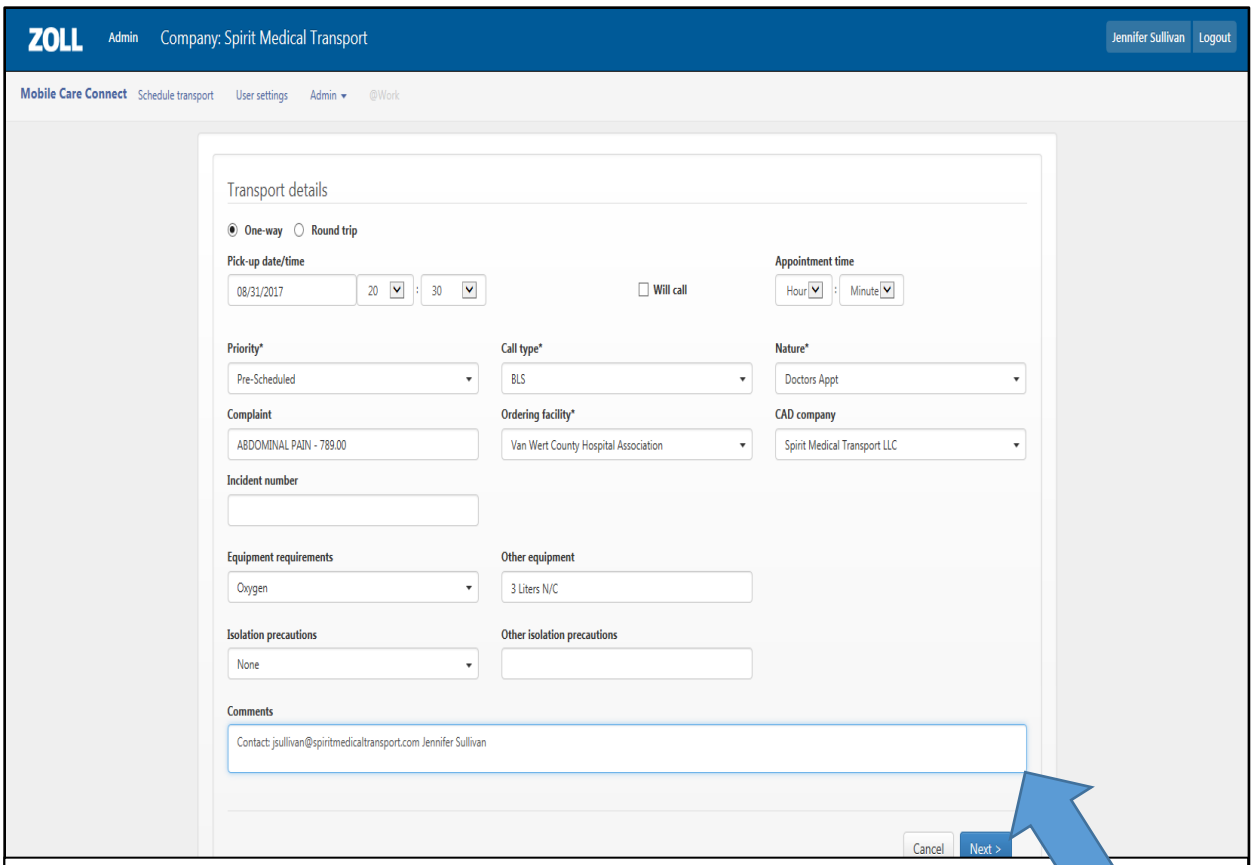
Emergency – patient needs to go to the ER right now, lights and sirens
PLEASE CALL US IMMEDIATELY, **do not** enter this type of call system
Immediate - transport is needed today, but is not an emergency
Prescheduled - Doctor Appointments or Outpatient Procedures scheduled for future dates

Call Type*:

ALS - *Advanced Life Support* – This is when a Paramedic is required. This is for patients that have an IV.
ALS BARIATRIC - For patients weighing over 400 lbs.
BLS - *Basic Life Support – EMT*. This is for a stretcher transport not requiring anything but at the most 0xygen.
BLS BARIATRIC - For patients weighing over 400 lbs.
WHEELCHAIR - For a patient who requires a wheelchair transport to their appointment or procedure
WHEELCHAIR DISCHARGE TO NURSING HOME - For a patient who requires a wheelchair transport that is going to another nursing home.
WHEELCHAIR DISCHARGE TO RESIDENCE - For a patient who requires a wheelchair transport that is returning home.

Nature*:

Doctor Appointment
Outpatient Procedure



PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS;
THEN COPY AND PASTE INTO THE COMMENT SECTION SHOWN ABOVE:

1. Will your facility be responsible to pay for the incurred costs of this transport? **[i.e. Yes, Patient is skilled]**

2. What medical conditions with the patient currently exist which require the patient to be transported by (ambulance, wheelchair) and inadvisable to transport the patient by any other means? **[i.e. Weakness; Fall Risk; Unsteady Gait; on 02]**

3. If stretcher: Does the patient meet bed confinement criteria meaning they meet ALL of the following criteria: They are unable to get out of bed without assistance; unable to ambulate, and unable to safety sit in a wheelchair? **NO**

   If yes, what medical condition is this related to?

4. What is the medical condition the patient has that he/she will be seen for? **[Please be specific – "Follow-up" does not have an ICD-10 diagnosis code. i.e. Chemo Therapy: Throat Cancer]**

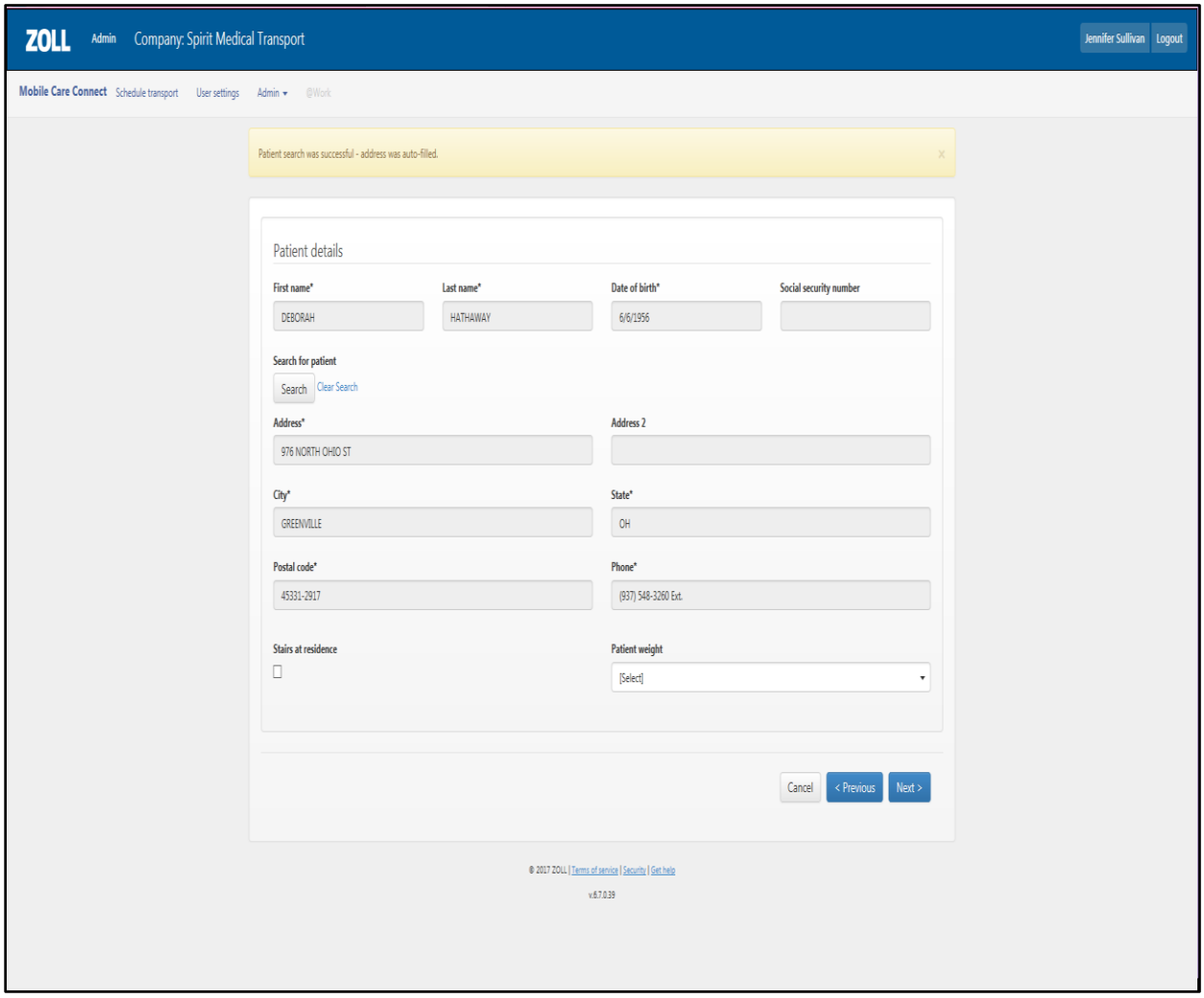
5. What type of physician specialist/procedure is this? **[i.e. Outpatient]**

6. What is the full first and last name of the ordering physician and his/her credentials? [i.e. **Dr. Thomas Brown MD]**

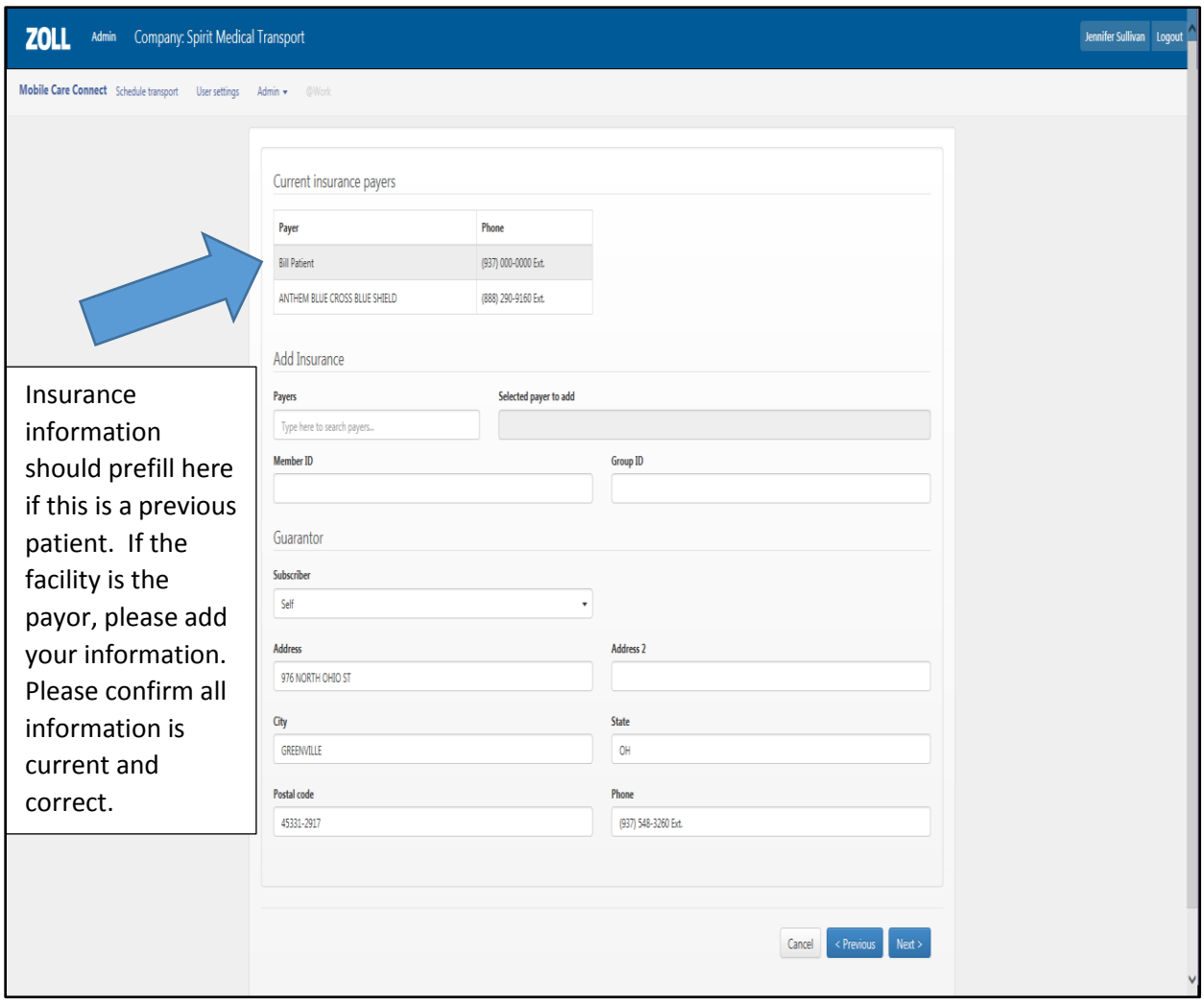
If a stretcher or wheelchair is going to a personal residence: Are there any steps that the crew will have to maneuver to safety get the patient into the residence? If yes, how many?

Then click Next>

Put in the patient's complete first and last name, then their date of birth. Then click on search. If the patient is in your data base, it should pre-fill the rest of the patient's information in the blanks. Please confirm that all the auto-filled information is current. Please correct anything that needs updated. If this is a first time patient, then complete all the required information.

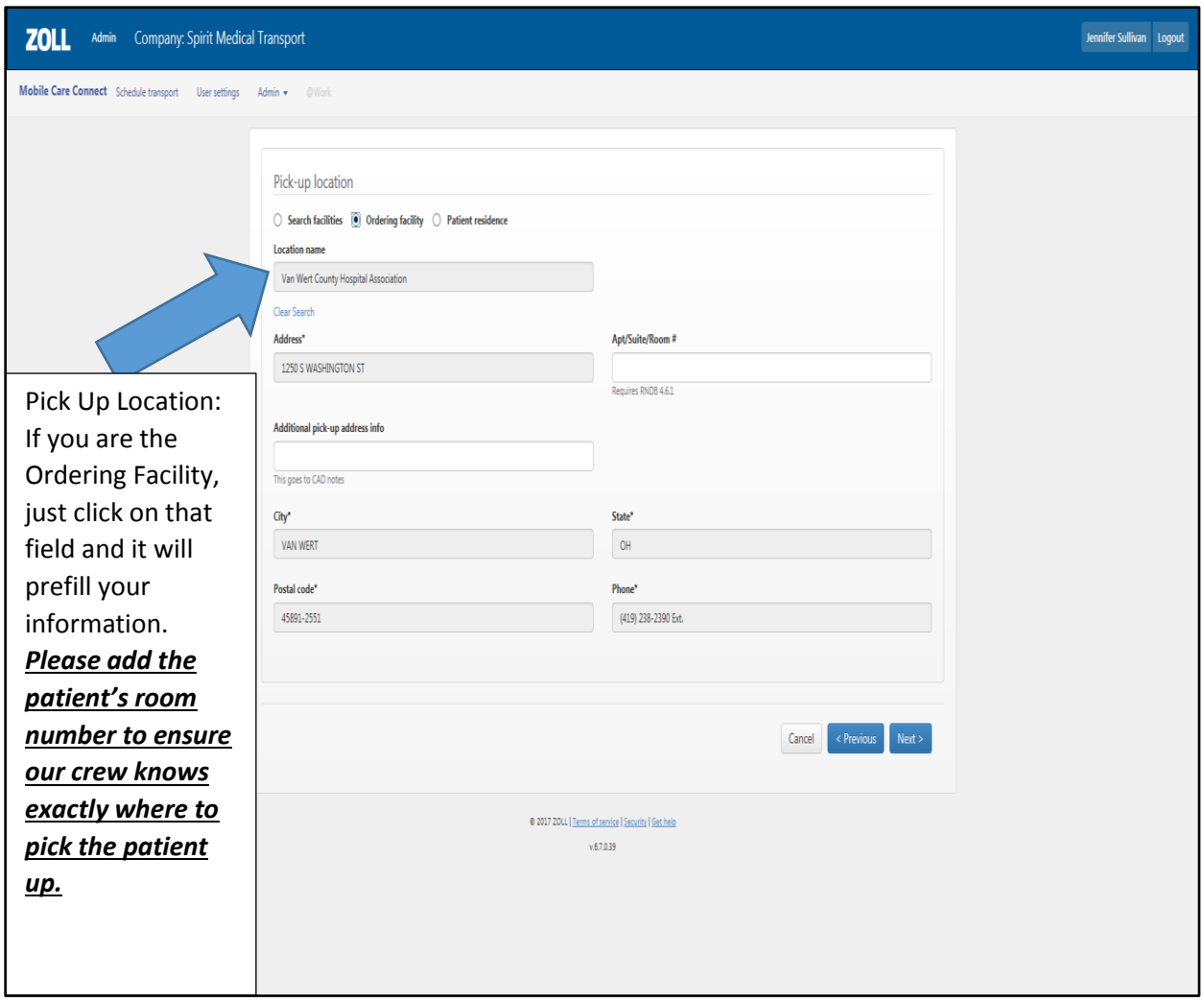


Then click Next>



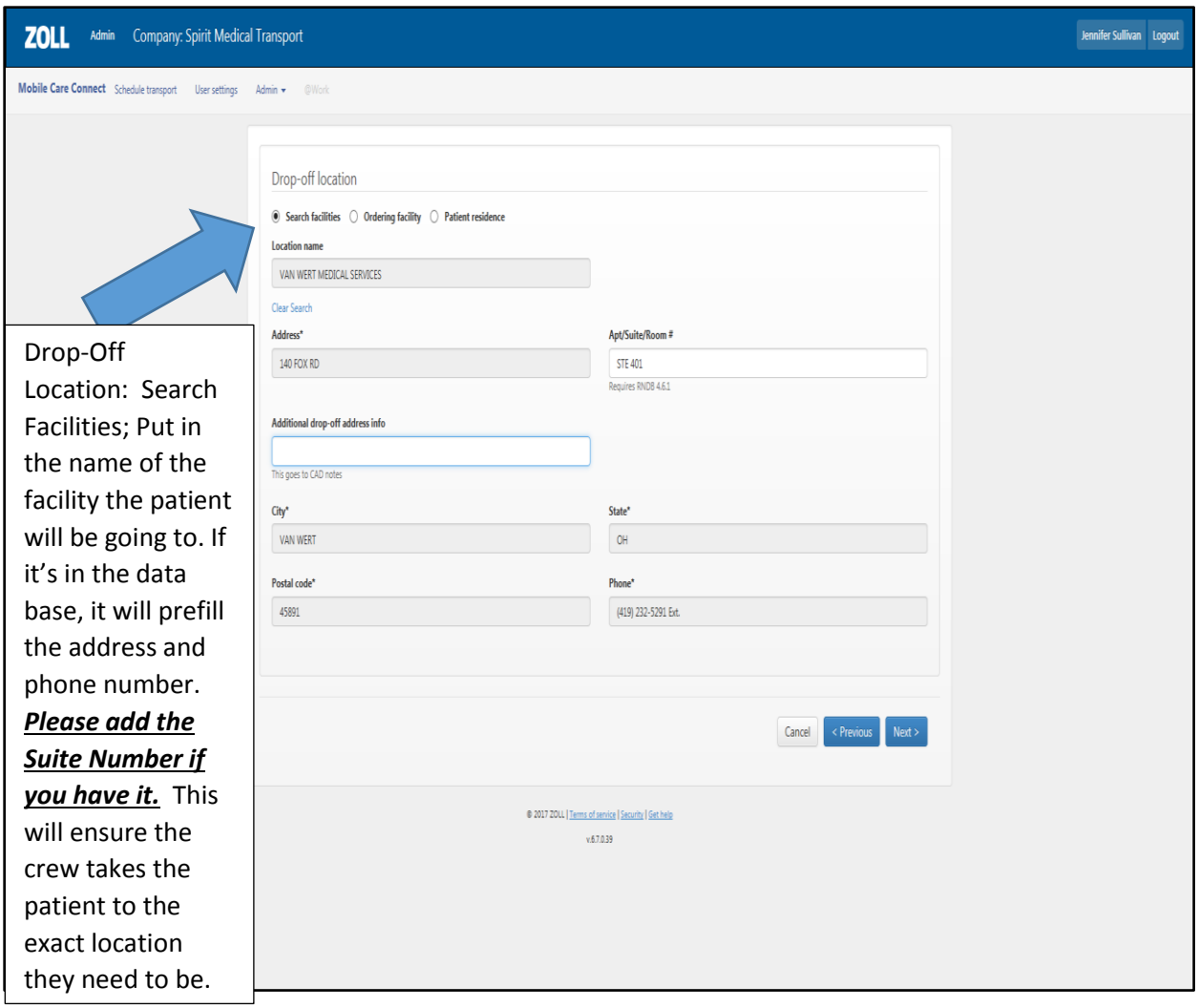
Insurance information should prefill here if this is a previous patient. If the facility is the payor, please add your information. Please confirm all information is current and correct.

Then click Next>



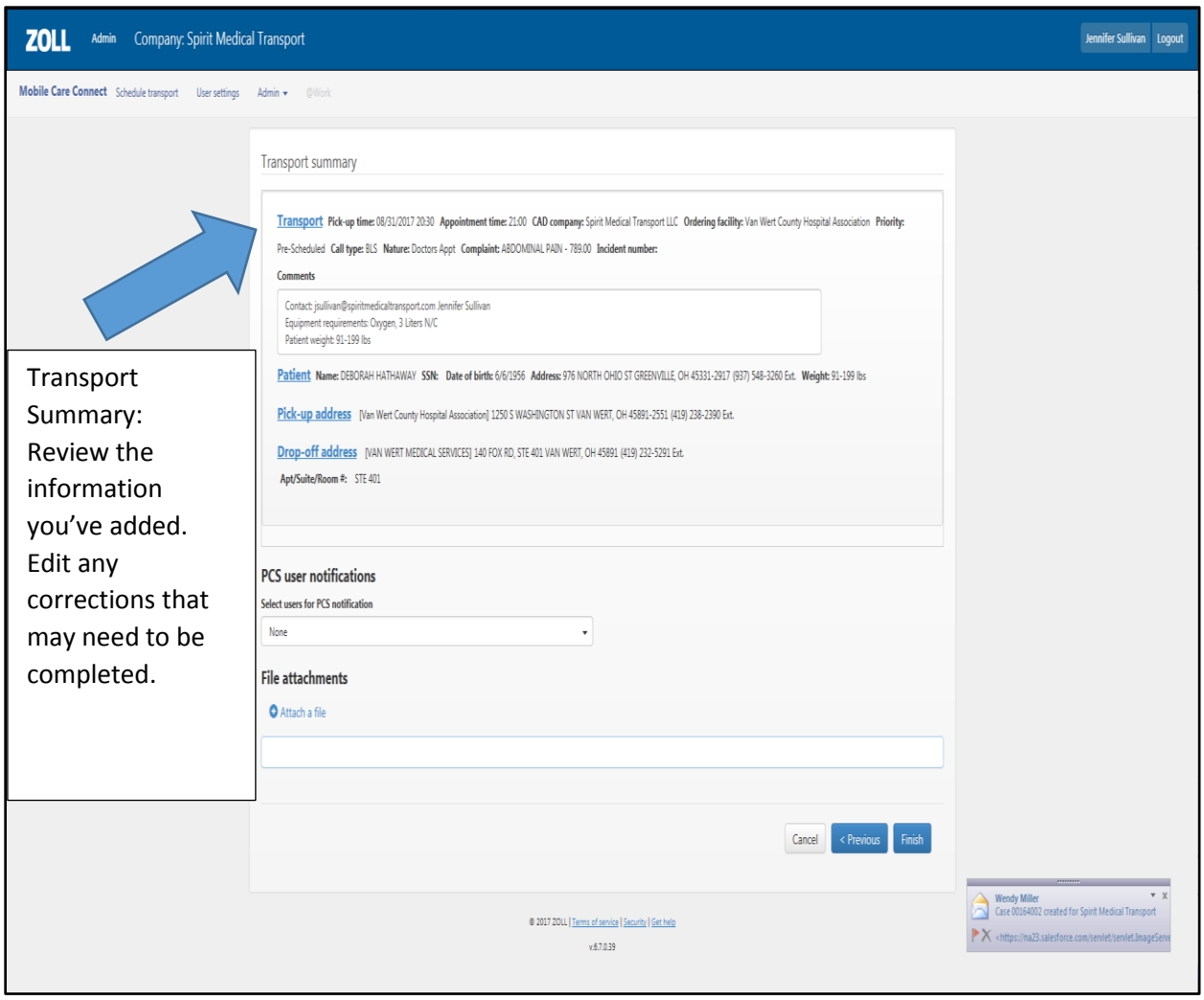
Pick Up Location: If you are the Ordering Facility, just click on that field and it will prefill your information. ***Please add the patient's room number to ensure our crew knows exactly where to pick the patient up.***

Then click Next>



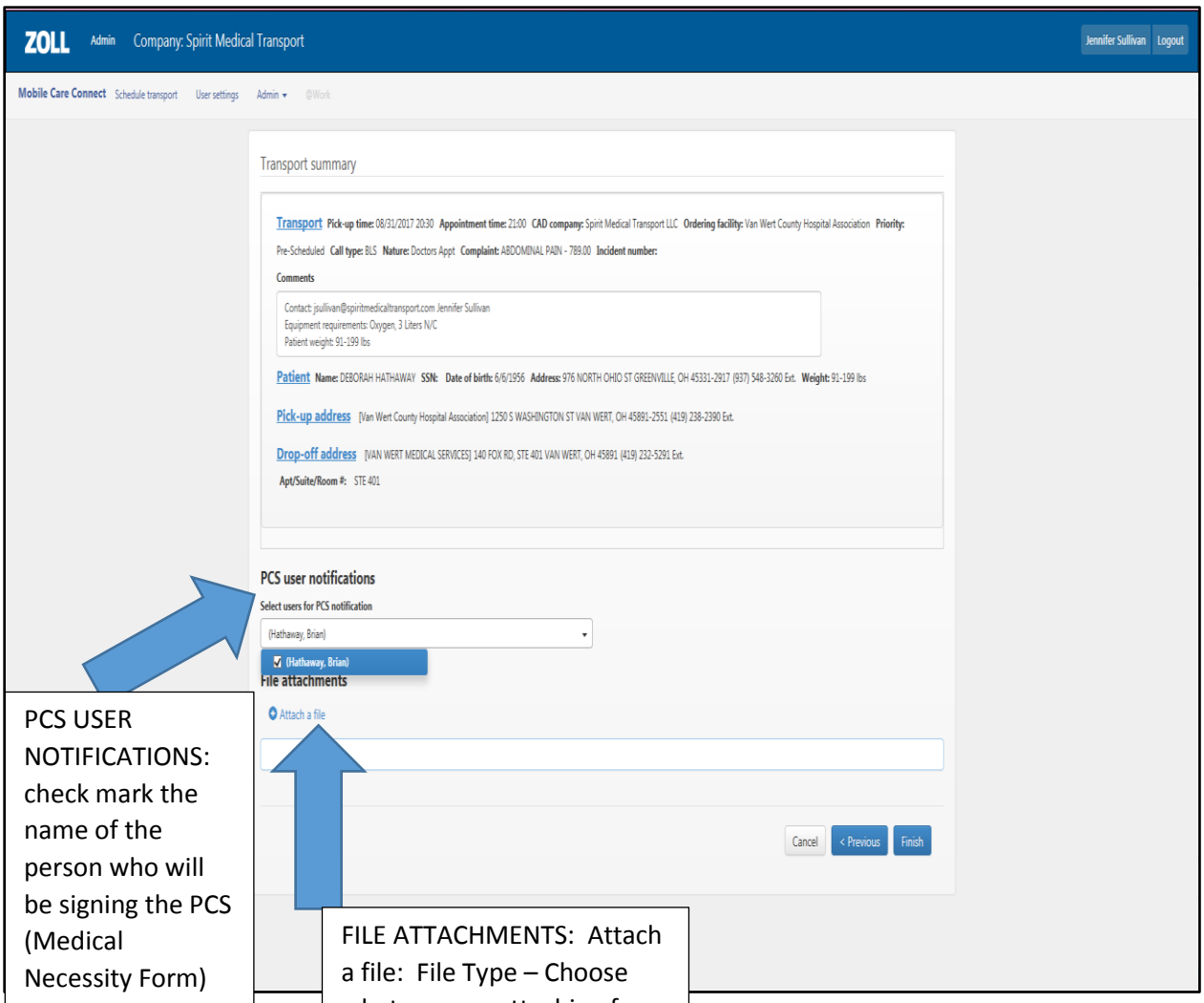
Drop-Off Location: Search Facilities; Put in the name of the facility the patient will be going to. If it's in the data base, it will prefill the address and phone number. ***Please add the Suite Number if you have it.*** This will ensure the crew takes the patient to the exact location they need to be.

Then click Next>



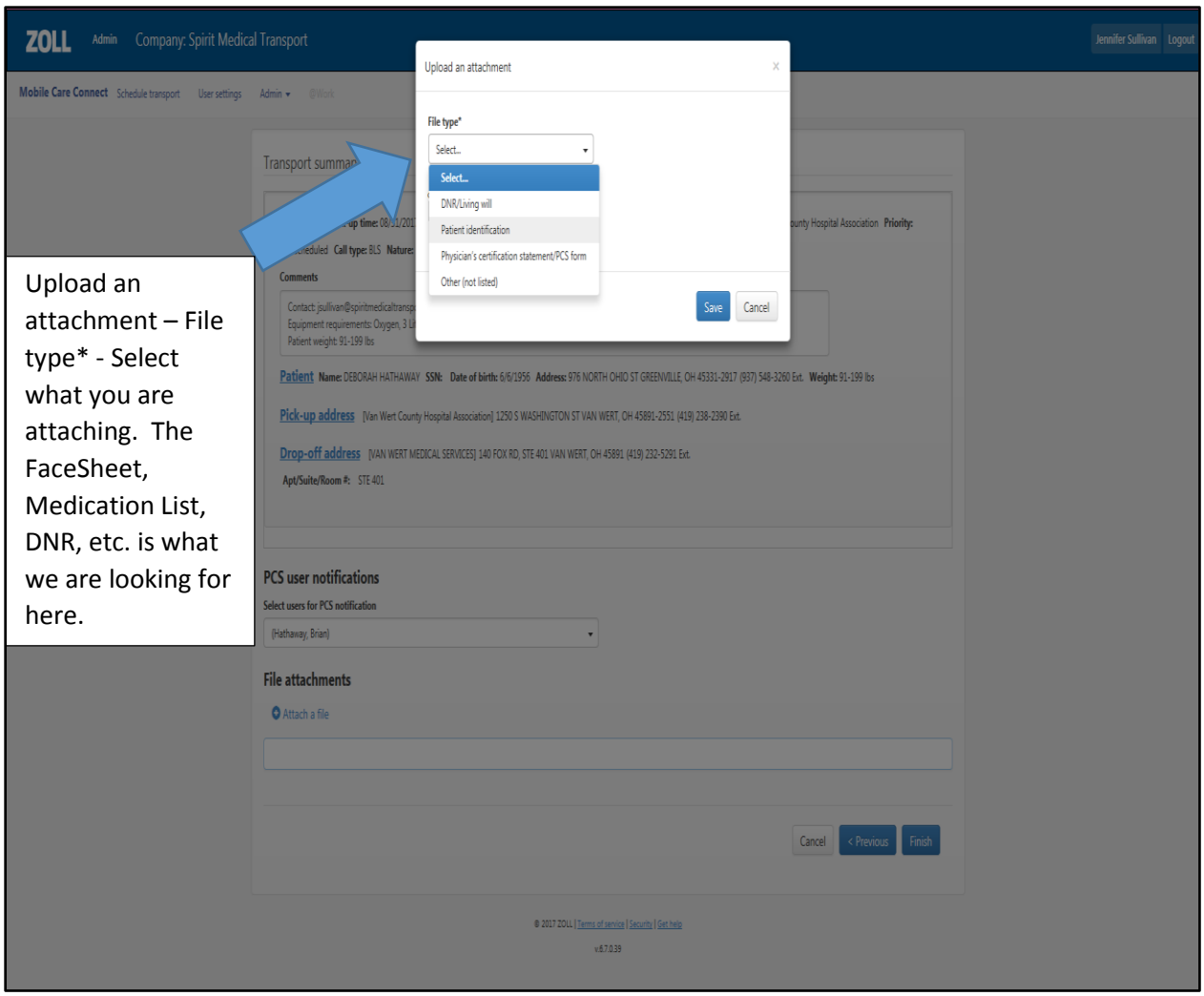
Transport Summary: Review the information you've added. Edit any corrections that may need to be completed.

Then click Next>

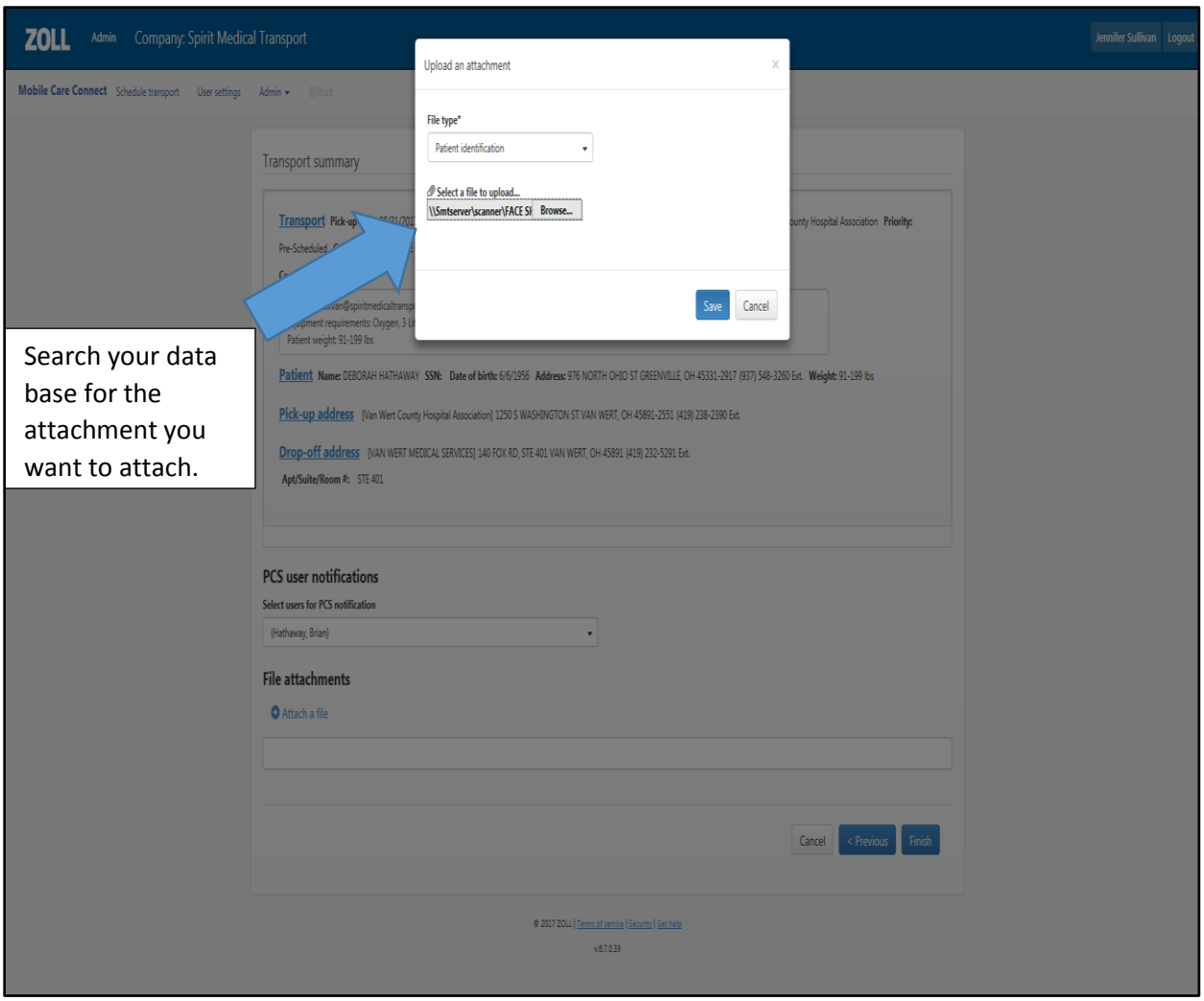


PCS USER NOTIFICATIONS: check mark the name of the person who will be signing the PCS (Medical Necessity Form)

FILE ATTACHMENTS: Attach a file: File Type – Choose what you are attaching from the drop down menu.

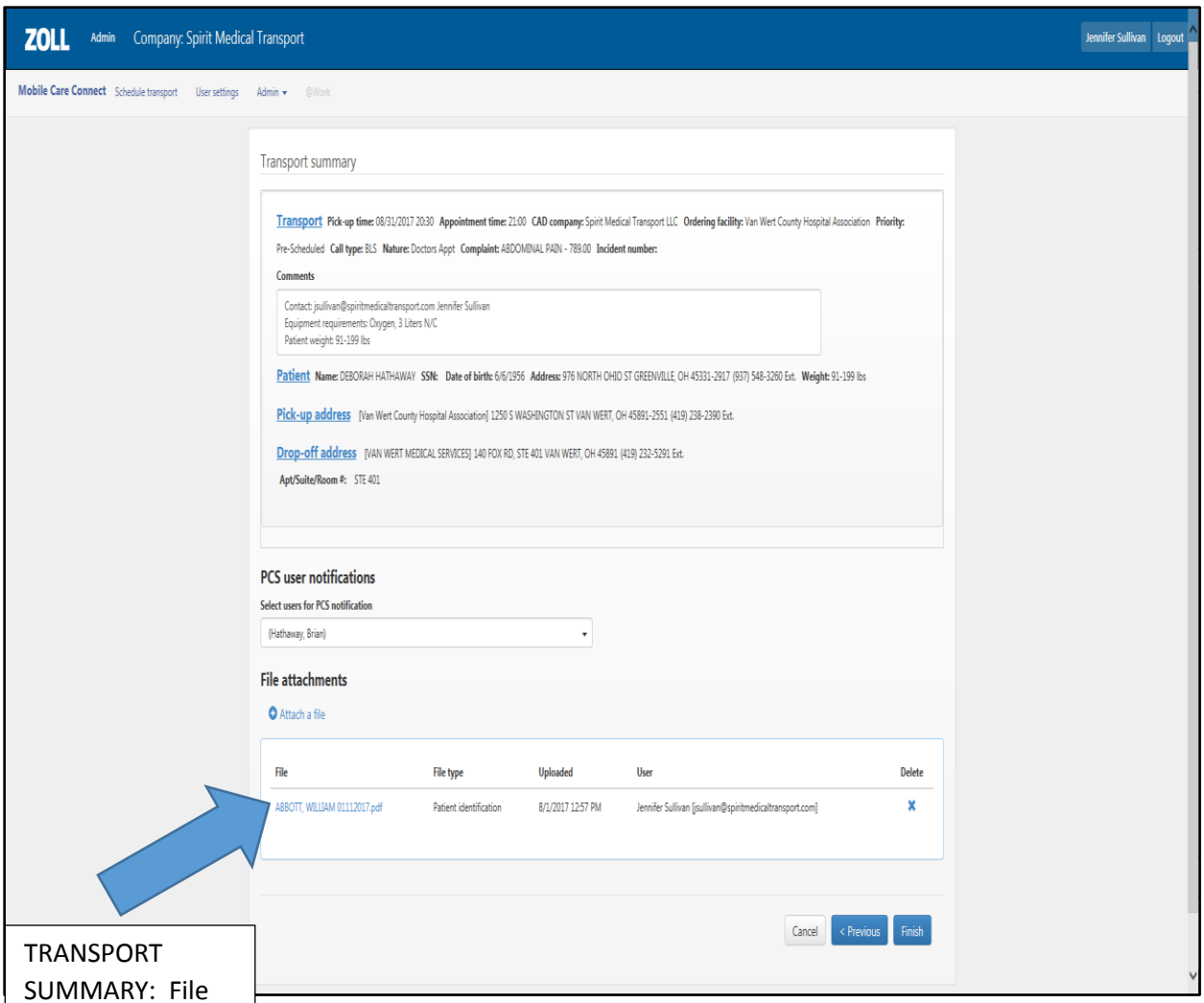


Upload an attachment – File type* - Select what you are attaching. The FaceSheet, Medication List, DNR, etc. is what we are looking for here.



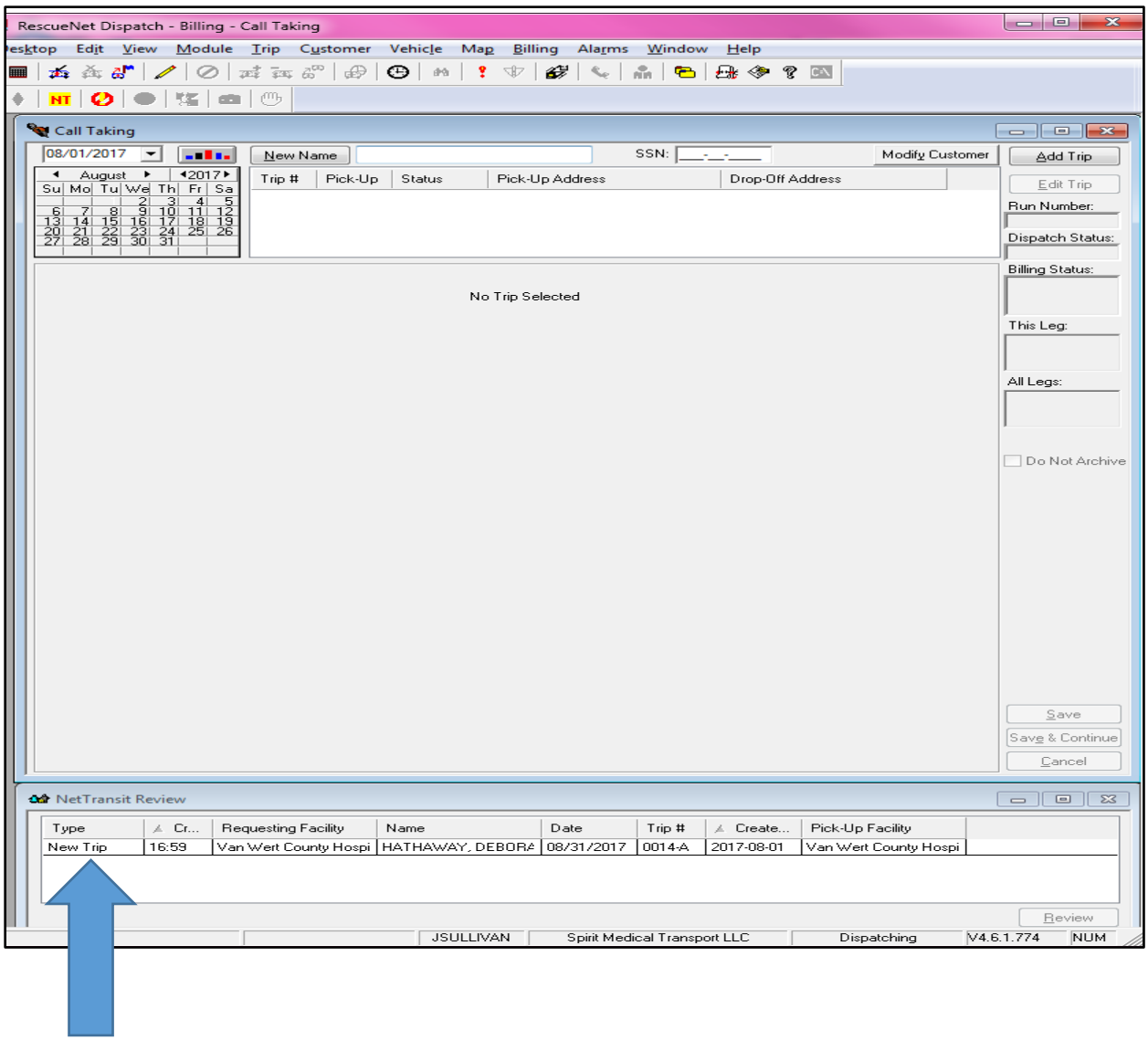
Search your data base for the attachment you want to attach.

Then click Save



TRANSPORT SUMMARY: File Attachments now shown.

Then click Finish



The transport will then pop into our data base for us to review and accept. If you have set up to receive emails or texts regarding this transport, you'll receive a notification from me that I've either accepted the transport, I've made notes to you concerning any additional information needed, or changes that I need to make to the requested scheduled. This may be a change in the pickup time, for example.

You will next receive an email stating the PCS (Medical Necessity Form) is ready to be signed. When you click on the link, it will bring up the PCS. You can electronically sign it and it will attach automatically to the scheduled transport.

ZOLL
Advancing Resuscitation. Today.™

Physician Certification Statement (PCS)

for ambulance transport

Patient name:

Date of transport: 7/18/2017

Pick-up location: WAYNE HEALTHCARE [dba] - Emergency Department; 835 SWEITZER ST - ed 3, GREENVIL

Drop-off location: Good Samaritan Hospital & Health Center; 2222 PHILADELPHIA DR - RM 5344, DAYTON, OH

Patient DOB: Weight: 91-199 lbs SSN:

Patient address: , New Paris , Oh, 45347

Equipment requirements: IV

Isolation precautions:

Contact person: Caitlin Kelly

The actual PCS (Medical Necessity Form) will include all of the patient's demographic information.

Medical necessity section:

(1) Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition:

patient has a liver mass and thrombus IVC - needs higher level of care

(2) Is this patient "bed confined" as defined below? ☐

To be "bed confined" the patient must satisfy all three of the following conditions: (1) unable to get up from bed without assistance; AND (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair.

(3) Please check any of the following conditions that apply:

Note: supporting documentation for any boxes checked must be maintained in the patient's medical records

- ☐ Patient is confused/combative/comatose
- ☐ Danger to self/other
- ☑ IV meds/fluids required
- ☐ Requires oxygen – unable to self administer
- ☐ Special handling/isolation/infection precautions required
- ☐ Cardiac monitoring required enroute
- ☐ Morbid obesity requires additional personnel/equipment

This PCS (Medical Necessity Form) is for all ambulance transports **EXCEPT Medicaid and Medicaid HMO covered patients**.

Disclaimer: I certify that this information is true and correct based on my evaluation of this patient, to the best of my knowledge and professional training. I understand that this information will be used by the Department of Health and Human Services (DHHS) and Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services.

Signed by: CAITLIN KELLY

Signature Date: 7/18/2017 Job Title: Discharge Planner

Signature: Caitlin Kelly

Ohio Department of Medicaid

CERTIFICATION OF NECESSITY FOR NON-EMERGENCY TRANSPORTATION BY GROUND AMBULANCE

Individual Information

1. Name *(Enter the full name of the individual transported.)*	2. Ohio Medicaid Billing Number — *12 Digits*
3. Address *(Enter the individual's home address. This information may be used to confirm the identity of the individual.)*	

Transportation Provider Information

4. Provider Name *(Enter the business name of the transportation provider.)*	
SPIRIT MEDICAL TRANSPORT, LLC	
5. Ohio Medicaid Provider Number — *7 Digits*	6. National Provider Identifier (NPI) — *10 Digits*
2740421	1326121104

Certification

7. Criteria *(Mark each reason why transport is being certified as necessary for this individual.)*	8. Period Beginning Date *(Enter the first date of the certification period.)*
During transport, this individual requires: ☒ medical treatment or continuous supervision by an EMT. ☐ the administration or regulation of oxygen by another person. ☐ supervised protective restraint.	9. Length *(Mark one box to indicate the length of time for which the individual is certified for transport. For certification on a temporary basis, specify the number of calendar days, up to 90. If no time period is indicated, then the certification is valid for the Period Beginning Date only.)* ☐ Not more than 1 day(s) ☐ One year

Additional Information Relevant to Certification

10. Comments or Explanations, If Necessary or Appropriate

Certifying Practitioner Information

11. Name of Practitioner *(Enter the full name of the certifying practitioner.)*	
12. Ohio Medicaid Provider Number, If Applicable — *7 Digits*	13. National Provider Identifier (NPI) — *10 Digits*

Signature Information

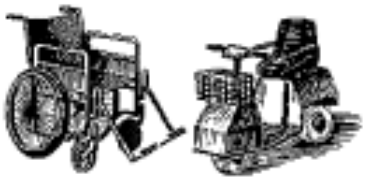
14. Date of Signature	15. Name of Person Signing
16. Signature and Professional Designation *(Persons who, with proper authority or approval, sign on behalf of the certifying practitioner must include the practitioner's name as well as their own signature and designation or job title.)*	

False certification constitutes Medicaid fraud.

This form confirms the certification of one individual for transport by one service provider; certification is not transferrable between individuals or service providers. A photocopy, an electronic copy, or a facsimile transmittal of the completed, signed, and dated certification form is as valid as the original for documentation purposes. Completion of this form is required in accordance with Chapter 5160-15 of the Ohio Administrative Code.

ODM 01960 (Rev. 7/2015)

This PCS (Medical Necessity Form) is for ambulance transports scheduled for **Medicaid and Medicaid HMO covered patients**.



Ohio Department of Medicaid

CERTIFICATION OF NECESSITY FOR TRANSPORTATION BY WHEELCHAIR VAN

Individual Information

1. Name *(Enter the full name of the individual transported.)*	2. Ohio Medicaid Billing Number — *12 Digits*
3. Address *(Enter the individual's home address. This information may be used to confirm the identity of the individual.)*	

Transportation Provider Information

4. Provider Name *(Enter the business name of the transportation provider.)*	
SPIRIT MEDICAL TRANSPORT, LLC	
5. Ohio Medicaid Provider Number — *7 Digits*	6. National Provider Identifier (NPI), If Applicable — *10 Digits*
2737767	1326121104

Certification

7. Criteria	8. Period Beginning Date *(Enter the first date of the certification period.)*
By signing this document, the practitioner certifies that two statements are true: a. This individual must be accompanied by a mobility-related assistive device from the point of pick-up to the point of drop-off. b. Transport of this individual by standard passenger vehicle or common carrier is precluded or contraindicated.	9. Length *(Mark one box to indicate the length of time for which the individual is certified for transport. For certification on a temporary basis, specify the number of calendar days, up to 90. If no time period is indicated, then the certification is valid for the Period Beginning Date only.)* ☐ Not more than 1 day(s) ☐ One year

Additional Information Relevant to Certification

10. Comments or Explanations, If Necessary or Appropriate

Certifying Practitioner Information

11. Name of Practitioner *(Enter the full name of the certifying practitioner.)*	
12. Ohio Medicaid Provider Number, If Applicable — *7 Digits*	13. National Provider Identifier (NPI) — *10 Digits*

Signature Information

14. Date of Signature	15. Name of Person Signing
16. Signature and Professional Designation *(Persons who, with proper authority or approval, sign on behalf of the certifying practitioner must include the practitioner's name as well as their own signature and designation or job title.)*	

False certification constitutes Medicaid fraud.

This form confirms the certification of one individual for transport by one service provider; certification is not transferrable between individuals or service providers. A photocopy, an electronic copy, or a facsimile transmittal of the completed, signed, and dated certification form is as valid as the original for documentation purposes. Completion of this form is required in accordance with Chapter 5160-15 of the Ohio Administrative Code.

ODM 03452 (Rev. 7/2015)

This PCS (Medical Necessity Form) is for **all wheelchair transports.**

SPIRIT MEDICAL TRANSPORT LLC.

5484 State Route 49 South
Greenville, Ohio 45331
Dispatch: 937-548-2800 Toll Free: 866-548-2818
Fax: 937-548-2826

PATIENT "CLOSEST APPROPRIATE FACILITY" QUESTIONAIRE

Patient's Name _____ Date of Transport _____ Incident Number _____

INFORMATION: Medicare and a host of other insurance companies only cover ambulance transportation to the "closest appropriate facility." Simply put, unless we have documentation to the contrary, if "Hospital A" offers the same service and/or physician specialty as "Hospital B," and we transport to "Hospital B" which is of greater distance simply because the patient has a developed relationship with a physician at that facility, the referring physician chose that facility for the patient and/or the patient desires to go to the more distant facility, Medicare and some other insurance companies require us to charge the patient for the additional mileage traveled beyond "Hospital A" in the absence of documentation that "Hospital B" was the closest appropriate hospital that met the medical needs of the patient at the time of the needed transport. Therefore, it's essential for us to know in cases where we may have been forced to travel farther, the reason the patient didn't go to the closer facility was because there were no beds available, a team of physician specialists/equipment needed to care for the patient wasn't immediately available at the closer location, there was no physician at the closer facility willing to accept the patient, etc. With that said, we ask you the following questions:

1. What is your medical diagnosis?

   _____

2. Were you ever seen by a local physician for this diagnosis? Yes No

2a. If yes, who treated you locally: (Name of physician and hospital)

_____

2b. If no, who initially treated you for this condition or how were you referred?

_____

3. How long have you been going to this specialty physician(s)/hospital? (Years, year diagnoses etc.)

   _____

4. Were any type treatments done locally before you were referred? Yes No
   (What treatments do you recall and were they successful?)

   _____

5. How did it come about that you were referred to the specialty physician/hospital in which you were/are being transferred?

   _____

6. What services/physician specialty for treatment that is available at the far distant hospital, that isn't otherwise available any place closer?

   _____

7. Has any hospital or specialty physician locally been willing to oversee your care and/or treat you since being referred to the more distant location? Yes No

7a. If yes, please specify who and provide additional details:

_____

Please use the back of this form if additional space is needed

This form is completed for **ALL transports** that are **over 50 miles**.

Certification of Medical Appropriateness

SPIRIT MEDICAL TRANSPORT LLC.

Patient's Name | Date of Transport | Incident Number

Dear Physician:

Medicare and a host of other insurance companies only cover ambulance transportation to the "closest appropriate facility." Simply put, unless we have documentation to the contrary, if "Hospital A" offers the same service and/or physician specialty as "Hospital B," and we transport to "Hospital B" which is of greater distance simply because the patient has a developed relationship with a physician at that facility, the referring physician chose that facility for the patient and/or the patient desires to go to the more distant facility, Medicare and some other insurance companies require us to charge the patient for the additional mileage traveled beyond "Hospital A" in the absence of documentation that "Hospital B" was the closest appropriate hospital that met the medical needs of the patient at the time of the needed transport. Therefore, it is essential for us to know, in cases where we may have been asked to travel farther, the circumstances that influenced your decision for the patient to be transported to a facility of greater distance. With that said, we ask you the following questions:

1. What is the patient's medical diagnosis for which they are being transferred? _____
2. Could this diagnosis be managed at a closer facility than the one the patient is being transferred to? ☐ Yes ☒ No
3. The services, equipment, and / or physician specialty that is available at the receiving facility and not available at the call location is: (Check all that apply)

☐ Inpatient Adult Behavioral Health Services	Diagnostic Radiology	☐ Oncology Services	☐ Nephrologists	☐ Pulmonologist
☐ Inpatient Youth Behavioral Health Services	☐ CT ☐ X-ray	☐ Pediatric Services	☐ Neurologist	☐ Rheumatologist
☐ Inpatient Geriatric Behavioral Health Services	☐ MRI ☐ Ultrasound	☐ Hemodialysis	☐ Obstetrician / Gynecologist	☐ Urologist
☐ Inpatient hemodialysis Unit	☐ _____	☐ Cardiologist	☐ Oncologist	☐ General Surgeon
☐ Emergency Medicine	☐ Venous Doppler	☐ Invasive Cardiac Services	☐ Ophthalmologist	☐ Hand Surgeon
☐ Skilled Nursing Services	☐ Nuclear Radiology	☐ Dermatologist	☐ Otolaryngologist (ENT)	☐ Orthopedic Surgeon
☐ Assisted Living Services	☐ Oncology Radiation	☐ Endocrinologist	☐ Pathologist / Biopsy	☐ Plastic/Reconstructive Surgeon
☐ Home Health Services	☐ STAT Blood Work	☐ Family Physician	☐ Physical Therapist	☐ Thoracic Surgeon
☐ Residential Institution	☐ Infectious Disease	☐ Gastroenterologist	☐ Podiatrist	☐ Vascular Surgeon
	☐ Intensive Care Bed	☐ Hematologist	☐ Psychiatrist	☐ Other:

4. Additional circumstances that led to this patient being transferred to this specific hospital included: (Check all that apply)

☐ No beds were available at a closer facility	☐ Subspecialty intervention for vascular emergency
☐ A team of physician specialists/equipment needed to care for the patient wasn't immediately available at the closer location	☐ Diagnostics or intervention for a neurological or injury or impairment
☐ Due to the complexity of the case, there was no physician at the closer facility willing to accept the patient	☐ Surgical or medical specialist for gastro-intestinal injury or disease
☐ Subspecialty intervention for a multi-system trauma	☐ Re-implantation team for an extremity injury
☐ Subspecialty intervention for an orthopedic injury	☐ Burn center care for thermal, chemical or electrical injuries
☐ Specialized pediatric care for a pediatric injury/illness	☐ Invasive diagnostics/intervention for a cardio-thoracic condition or disease
☐ High-risk obstetrical services	☐ Continuity of care related to_____
☐ Hyperbaric treatment for toxic exposure or other emergent injury	☐ Other (please describe) _____
☐ Level III nursery care for neonatal emergency	
☐ Sepsis	

I certify I have completed this report based upon the information available to me at the time of the patient's transport. I further affirm that the information contained in the sections above represent an accurate assessment of the beneficiary's medically necessary need(s) for the above mentioned ALS/BLS Ambulance Transportation Services.

Printed first and last name of physician ordering ambulance transportation must be specified below:

☐ MD ☐ DO

Printed Physician's first and last name and check credentials

Physician's signature | Date

For non-repetitive, unscheduled ambulance transports, the forms may be signed by any of the following if the attending physician is unavailable to sign (please check the appropriate box below)

Printed Healthcare Professional's first and last name and credentials

Healthcare Professional's signature | Date

☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Registered Nurse
☐ Nurse Practitioner ☐ Discharge Planner

SPIRIT MEDICAL TRANSPORT LLC.

Completed forms may be given to Spirit Medical Transport personnel at the time of transport or Fax directly to 937-548-2826

Please use the back of this form if additional space is needed

This form is completed for ambulance transports that are **over 50 miles**.